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BRIEF SUMMARIES

of

Medicare and Medicaid

Title XVIII and Title XIX

of the

The Social Security Act

with 1993 data



July, 1994

Note: These summaries are very brief, simple versions of very complex subjects. These summaries should be used only as general guides or overviews of the Medicare and Medicaid programs.

MEDICARE: A BRIEF SUMMARY

OVERVIEW

Title XVIII of the Social Security Act, entitled "Health Insurance for the Aged and Disabled," is commonly known as "Medicare." As part of the Social Security Amendments of 1965, the Medicare legislation established a health insurance program for aged persons to complement the retirement, survivors and disability insurance benefits under other titles of the Social Security Act.

When first implemented in 1966, Medicare covered most persons age 65 and over. Since then, legislation has added other groups: (1) persons entitled to disability benefits for 24 months or more (1973); (2) persons with end stage renal disease (ESRD) requiring dialysis or kidney transplant (1973); and (3) certain otherwise non-covered persons who elect to buy into the programs (1973).

Medicare consists of two parts: hospital insurance (HI), also known as Part A; and supplementary medical insurance (SMI), also known as Part B. When Medicare began on July 1, 1966, there were 19.1 million persons enrolled in the Medicare programs. By the end of 1966, 3.7 million beneficiaries had received services covered by Medicare. In 1993, about 36.2 million persons were enrolled in one or both parts of the Medicare program. Over 83 percent (84 percent of the aged) of all Medicare "enrollees" used some HI and/or SMI service in FY 1993, and thus are the Medicare "beneficiaries" for that year.

MEDICARE (HI and SMI) COVERAGE

Hospital Insurance (Part A) is generally provided automatically for persons age 65 and over and to most persons who are disabled for 24 months or more who are entitled to Social Security or Railroad Retirement benefits. A major aspect of Part A is the "benefit period," defined as the measurement of time-duration for inpatient care, starting when the beneficiary first enters a hospital, and ending when there has been a break of at least 60 consecutive days since inpatient hospital or skilled nursing care was provided. There is no limit to the number of benefit periods covered by Part A during a beneficiary's lifetime.

If a beneficiary exhausts the 90 days of inpatient hospital care available in a benefit period, he or she can use days from a non-renewable "lifetime reserve" of up to 60 additional days of care. In addition to the limits on number of days covered for inpatient hospital care and skilled nursing facility care, HI has co-payment requirements (explained later). The following describes the health services for which Medicare HI reimburses participating institutional providers: inpatient hospital, skilled nursing facility, home health, and hospice services that are rendered to beneficiaries who are enrolled in Part A.

o Inpatient hospital care coverage includes costs of a semi-private room, meals, regular nursing services, operating and recovery room, intensive care, drugs, laboratory tests, X-rays, and all other medically necessary services and supplies.

o Skilled nursing facility (SNF) care is covered by Medicare HI only if it follows within 30 days (usually) a hospitalization of 3 or more days, and is certified as medically necessary. Covered services are similar to inpatient hospital, plus rehabilitation services and appliances. The number of SNF days provided under Medicare is limited to 100 per benefit period, with a co-payment required for days 21 through 100. Medicare Part A does not cover nursing facility care at all if the patient does not require skilled nursing, or other skilled rehabilitation services which must be given on an inpatient basis.

o Home health agency (HHA) care, including a home health aide, may be furnished by a home health agency in a home-bound beneficiary's residence if intermittent or part-time skilled nursing, physical therapy or rehabilitation care is necessary. There must be a plan of treatment and periodical review by a physician. Home health care under Part A has no time limitations, no co-payment, and no deductible. However, full-time nursing care, food, blood, and drugs are not provided as HHA services.

o Hospice care, added in 1983, is a service provided to those terminally ill persons with a life expectancy of six months or less who elect to forgo traditional medical treatment for the terminal illness, and to receive only limited (hospice) care. Such care includes pain relief, supportive medical and social services, physical therapy, nursing services and symptom management for a terminal illness. However, if a hospice patient requires treatment for a condition not related to the terminal illness, Medicare will pay for all necessary covered services. For the hospice program, the Medicare beneficiary pays a very small coinsurance amount for drugs and the cost of respite care, but pays no deductibles. However, there is a "cap" on per person hospice expenditures.

Supplementary Medical Insurance (Part B) benefits are available: to almost all resident citizens age 65 and over; to certain aliens age 65 or over - even to those who are not entitled (based on eligibility for Social Security or Railroad Retirement benefits) to Medicare's Part A services; and to disabled beneficiaries who are entitled to Medicare's Part A. Part B coverage is optional, and must be paid for through a monthly premium. Almost all persons entitled to Part A also choose to enroll in Part B.

Part B is often thought of primarily as coverage for physician services (in both hospital and non-hospital settings). However, SMI also covers certain other non-physician services, including: clinical laboratory tests, durable medical equipment, flu vaccinations, drugs which cannot be self-administered (certain self-administered anticancer drugs are covered), most supplies, diagnostic tests, some other therapy services, ambulance services, certain other health care services and blood not supplied under Part A.

The expenditures for institutional services in hospital outpatient departments, ambulatory surgical centers and certain other centers are also covered. All services must be medically necessary to be covered. Certain medical services and related care are subject to special payment rules including: deductibles (for blood), maximum approved amounts (for independently practicing, Medicare-approved physical or occupational therapist), or higher cost sharing requirements (such as for outpatient treatment of a mental illness).

Non-covered services under Medicare include long-term nursing care or custodial care, and certain other health care needs such as eyeglasses, hearing aids, prescription drugs (except certain self-administered anticancer drugs), dentures and dental care, etc. These are not a part of either the HI or the SMI program (unless they are a part of a special "coordinated care plan" - discussed below).

MEDICARE FINANCING AND PAYMENTS

Medicare's expenses for both benefits and administration are paid from two separate trust funds. HI's funds accrue mainly from a tax on individuals' employment earnings. SMI's funds come from payment of premiums by or on behalf of individuals, plus general revenue contributions from the Federal Government. In addition, most Medicare covered services require some form of cost-sharing from beneficiaries.

Financing:

For Part A, financing is, primarily, through mandatory payroll deductions ("FICA tax") of 1.45 percent of taxable earnings for employees and employer each, as well as 2.90 percent for self-employed persons who pay into the HI trust fund. This hospital insurance trust fund is separate from the SMI trust fund, and from Social Security's Old Age and Survivors' Insurance and Disability Insurance trust funds. The HI trust fund is used only for HI expenses.

Prior to 1983, payment was made based on a "reasonable cost" basis. Medicare payments for most inpatient hospital care are now, since 1983, under a plan known as the Prospective Payment System (PPS). Under the PPS, a hospital is paid a predetermined amount, based upon the patient's diagnosis within a "diagnosis related group," (DRG) for providing whatever medical care is required during that person's inpatient hospital stay.

In some cases the payment received is less than the hospital's actual costs; in other cases it is more. The hospital absorbs the loss or makes a profit. Certain payment adjustments exist for extraordinarily costly cases. Payments for home health, hospice and skilled nursing care coverage continue to be paid under the reasonable cost methodology, with each service having some restrictions and limitations.

For Part B, financing is through premium payments (\$41.10 per month in 1994) which are usually deducted from monthly Social Security benefit checks of those who are voluntarily enrolled in the SMI plan, and

through significant matching contributions (a total of 65% in 1994) from the general revenue of the federal government.

Physicians are paid on the basis of "reasonable charge". This was defined as the lowest of (1) the physicians's actual charge, (2) the physicians's customary charge, or (3) the prevailing charge in the locality for similar services. Beginning January 1992, the reasonable charges are defined as the lesser of the submitted charges, or a fee schedule based on a relative value scale (RVS). Durable medical equipment and clinical laboratory services are also based on a fee schedule. Outpatient services and HHAs are reimbursed on a reasonable cost basis.

Beneficiary Payment Liabilities:

For Parts A and B, beneficiaries are responsible for charges not covered by the Medicare program, and for various cost sharing aspects of both HI and SMI. These liabilities may be paid by (1) the Medicare beneficiary, (2) by some other third party such as Medicaid, or (3) by some additional private insurance purchased by the Medicare beneficiary (medigap insurance). The term medigap is used to mean private health insurance which, within limits, pays most of the health care service charges not covered by Parts A or B of Medicare. Blue Cross (for Part A) and Blue Shield (for Part B), and many commercial health insurance companies offer such policies, which must meet certain standards imposed by law.

For Part A, the beneficiary's payment share for includes a one-time deductible amount at the beginning of each benefit period (\$696 in 1994)). This covers the beneficiary's part of the first 60 days of each spell of inpatient hospital care. If continued inpatient care is needed, additional coinsurance payments (\$174 per day in 1994) are required through the 90th day of a benefit period. Medicare pays nothing after day 90, unless the beneficiary elects to use "lifetime reserve" days, -- for which a co-payment (\$348 per day in 1994) is required from the beneficiary.

For skilled nursing care under Part A, the first 20 days of SNF care are fully covered by Medicare; but for days 21 through 100, co-pay (\$87 per day in 1994) is required from the beneficiary. After 100 days of SNF care per benefit period, Medicare pays nothing for SNF care. Home health care has no deductible or coinsurance. In any Part A service, the beneficiary is responsible for non-replacement fees for the first three pints or units of blood per calendar year. The beneficiary has the option of paying the fee or of having the blood replaced.

For most people age 65 and over, there are no premiums for the HI portion of Medicare. Eligibility for Part A is generally earned through the work experience of the beneficiary, or that of a spouse. However, some persons otherwise unqualified for Medicare may purchase HI coverage if they also buy the SMI coverage. If they have 30 quarters of coverage as defined by SSA, the 1994 cost of HI is the reduced amount of \$184 per month; if not, the cost is \$245 per month.

For Part B, the beneficiary's payment share includes: one annual deductible (now \$100); the monthly premiums; coinsurance payments for

Part B services (usually 20% of allowable charges); a blood deductible; and payment for any services which are not covered by Medicare. These "cost-sharing" contributions are required of the beneficiaries for SMI services. For ESRD patients, Medicare Part B assists in paying for kidney dialysis and transplants. The regular Part B cost-sharing payments also apply for ESRD services.

If a doctor or supplier agrees to accept the approved rate as payment in full ("takes assignment"), then payments provided must be considered as payments in full (after co-payments have been met) for that service. No added payments may be sought from the beneficiary or insurer. If the provider does not take assignment, then the beneficiary will be charged for the excess (which may be paid by the medigap insurance). Limits now exist on the excess which providers can charge. However, since Medicare beneficiaries may select their doctors, beneficiaries have the option to choose those who do agree to take assignment.

MEDICARE CLAIMS PROCESSING

Medicare "contractors" may be public or private organizations or agencies that contract with HCFA to serve as the fiscal agent between government and providers to locally administer Part A and Part B. Presently, all contractors are private insurance organizations.

Medicare "intermediaries" process Part A claims for institutional services, including inpatient hospital claims, skilled nursing facilities, home health agencies, and hospice services. They also process Part B outpatient claims. Examples of intermediaries are the Blue Cross and Blue Shield Association (which utilize Blue Cross plans in various States), or commercial insurance companies.

Intermediaries' responsibilities include:

- o determining costs and reimbursement amounts,
- o maintaining records,
- o establishing controls,
- o safeguarding against fraud and abuse or excess use,
- o conducting reviews and audits,
- o making the payments to providers for services, and
- o assisting both providers and beneficiaries as needed.

Medicare "carriers" handle Part B claims for services by physicians and medical suppliers. Some examples of carriers are the Blue Shield plan in a State or commercial insurance companies.

Carriers' responsibilities include:

- o determining charges allowed by Medicare,
- o maintaining quality of performance records,
- o assisting in fraud and abuse investigations,
- o assisting both suppliers and beneficiaries as needed, and
- o making the payments to physicians and suppliers for services which are covered under Part B.

"Peer Review Organizations" (PROs) are groups of practicing health care professionals who are paid by the federal government to review the care provided to Medicare beneficiaries in each State. PROs act to promote effective, efficient and economical delivery of health care services to the Medicare population they serve.

The Peer Review Organizations' responsibilities include:

- o deciding if care provided is reasonable and necessary,
 - o deciding if care is provided in an appropriate setting,
 - o reviewing the validity of hospitals' diagnostic information,
 - o reviewing the appropriateness of admissions and discharges,
 - o deciding if standards of quality are being met, and
 - o reviewing the appropriateness of care for which additional payment is sought for extraordinarily costly cases.
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MEDICARE COORDINATED CARE PLANS

Coordinated care (prepaid health care plans), such as competitive medical plans (CMPs) and health maintenance organizations (HMOs), is an option for Medicare beneficiaries. Coordinated care plans function on a basis different from regular fee-for-service plans. Under coordinated care plans, Medicare beneficiaries receive their medical services at a comprehensive health care setting within a service area. This public or private organization provides health care services at a predetermined per-person rate, regardless of frequency or extent of utilization by its enrollees. Coordination of all health care services is central to the HMO and CMP concept. To insure this coordination, all of the beneficiary's health care services, except for emergency care, are obtained from the professionals and facilities affiliated with the HMO or CMP which the beneficiary has selected.

In addition to those services which are usually provided under Medicare fee-for-service plans, the coordinated care plans often cover services such as preventive care, eyeglasses, dental care, or hearing aids. The election to participate in a coordinated care plan may also serve as an alternative to purchasing medigap insurance (described later) -- often wanted if the beneficiary is in a traditional fee-for-service plan. And, although there are certain restrictions and limitations, the coordinated care plan's larger fixed monthly premiums and smaller coinsurance payments help to provide more predictability for out-of-pocket costs for the beneficiaries who do not have medigap insurance.

MEDICARE - MEDICAID RELATIONSHIP

Medicaid (Title XIX of the Social Security Act) is a joint Federal and State cooperative program which provided health care services for over 33.4 million certain very poor persons in 1993, at a total cost of over \$125.8 billion. Within guidelines and regulations from the Federal government, the State elects a plan for its Medicaid program. Medicaid eligibility rules and Medicaid services vary from State to State; thus

persons and services that are covered in one State may not be covered in another. But Federal regulations must be followed if there is to be Federal matching money for the State's Medicaid program.

The Medicaid program assists certain Medicare beneficiaries under specific conditions. If a person is a Medicare beneficiary, payments for any services covered by Medicare are made by the Medicare program before any payments are made by the Medicaid program. Medicaid is always the payor of last resort. For the Medicare beneficiaries who are also fully eligible for Medicaid, Medicare coverage is supplemented by health care services that are available under the State's Medicaid program. As each State elects, services such as eyeglasses, hearing aids, and nursing facility care beyond the 100 day limit covered by Medicare may be provided by the Medicaid program.

In addition, there are others (QDWIs, QMBs or SLMBs - see below) who are not eligible for the regular Medicaid program, but who do receive some help through the State Medicaid program's payment of part or all of the person's beneficiary liabilities within Medicare. Qualified Disabled and Working Individuals (QDWIs) who lost Medicare benefits because of their return to work are allowed to purchase Medicare HI and SMI coverage. However, the HI premium must be paid by the State Medicaid program for those QDWIs with income below 200% of the Federal Poverty Level. Medicaid does not pay the SMI premiums for these QDWIs.

Medicaid assists certain other Medicare beneficiaries -- known as Qualified Medicare Beneficiaries ("QMBs") or Specified Low-Income Medicare Beneficiaries ("SLMBs") -- if they apply for help. For the QMBs (those Medicare-entitled persons with resources at or below twice the standard allowed under the SSI program, and with incomes below the FPL), the State pays all the Medicare HI and SMI premiums and cost-sharing expenses. For the SLMBs, (those like QMBs, but with slightly higher incomes: less than 110% of FPL in 1993 and 1994, and less than 120% in 1995), the State Medicaid programs pay (only) the SMI premiums.

ADMINISTRATION OF MEDICARE

The overall responsibility for administration of the Medicare program lies with the Department of Health and Human Services (DHHS) and the various components: the Health Care Financing Administration (HCFA), Public Health Service (PHS), and Social Security Administration (SSA). HCFA has primary responsibility for Medicare, including: policy and guidelines formulation; contract oversight and operation; maintenance and review of utilization records; and general financing of Medicare.

PHS is responsible for administering the professional health aspects of the Medicare program. SSA is responsible for the initial determination of an individual's entitlement and has overall responsibility for maintaining the Medicare master beneficiary record. The Department of Treasury manages both trust funds, and the transfer of funds to pay the bills. A Board of Trustees, which is composed of two appointed members and three ex-officio members, holds the trust funds for HI and SMI.

The Board of Trustees reports the status and operation of the Medicare trust funds to Congress on April first of each year.

State agencies (usually State Health Departments under agreements with HCFA) assist by helping DHHS to identify, survey, and inspect provider and supplier facilities or institutions wishing to participate in the Medicare program. In consultation with HCFA, they then certify those that are qualified. The State agency also coordinates the various State programs to assure effective and economical endeavors, and assists providers as a consultant.

TRENDS and SUMMARY:

The Medicare program covers ninety five percent of our nation's aged population, as well as many of the disabled on Social Security. In calendar year (CY) 1993, HI covered about 36 million enrollees at a cost of \$94.4 billion (expected to be \$107.2 billion in 1994). SMI covered 34.6 million enrollees in 1993 at a cost of \$57.8 billion (expected to total \$61.8 billion for CY 1994). Administrative costs were 1.0% of HI and 3.5% of SMI disbursements for 1993.

Combining the HI and SMI benefit payments for all Medicare services in CY 1993, the average disbursement per enrollee was \$4,111. Of those persons who were entitled to Medicare in 1993, over eighty percent use the Supplementary Medical Insurance services, while only twenty percent use the Hospital Insurance services.

The rising costs of health care is a major consideration for HCFA, for the President, and for Congress. The present financing schedule for the HI program is sufficient to ensure the payment of benefits only for the next seven years. Although the SMI program is currently actuarially sound, the past and projected growth in the cost of the program is of grave concern. For the long range: the SMI program costs are projected to increase from 0.88 percent of the Gross Domestic Product (GDP) in CY 1993 to 4.37 percent of GDP in CY 2068; and the HI program costs are projected to increase from 1.52 percent of GDP in CY 1993 to 4.98 percent of GDP in CY 2068. Projections for the more immediate future indicate that, if expenditures continue at the current rate with normal growth rate for the population and if there are no significant changes to the health care programs, then disbursements for the Medicare program for CY 1996 are estimated to be almost \$205 billion.

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MEDICAID: A BRIEF SUMMARY

OVERVIEW

Title XIX of the Social Security Act is a Federal-State matching entitlement program which provides medical assistance for certain individuals and families with low incomes and resources. The program, known as Medicaid, became law in 1965 as a jointly funded cooperative venture between the Federal and State governments to assist States in the provision of more adequate medical care to eligible needy persons. Medicaid is the largest program providing medical and health-related services to America's poorest people.

Within broad national guidelines which the Federal government provides, each of the States: (1) establishes its own eligibility standards; (2) determines the type, amount, duration, and scope of services; (3) sets the rate of payment for services; and (4) administers its own program. Thus, Medicaid programs vary considerably from State to State, as well as vary within each State over time.

BASIS OF ELIGIBILITY AND MAINTENANCE ASSISTANCE STATUS

States generally have broad discretion in determining which groups their Medicaid programs will cover and the financial criteria for Medicaid eligibility. However, to be eligible for Federal funds, States are required to provide Medicaid coverage for most individuals who receive Federally assisted income-maintenance payments, as well as for related groups not receiving cash payments. The following displays the mandatory Medicaid eligibility groups:

- o Recipients of Aid to Families with Dependent Children (AFDC);
- o Supplemental Security Income (SSI) recipients (or aged, blind and disabled individuals in States that apply more restrictive eligibility requirements);
- o Children under age 6 who meet the State's AFDC financial requirements or whose family income is at or below 133% of the Federal poverty level (FPL);
- o Pregnant women whose family income is below 133% of the FPL (services to the woman are limited to pregnancy, complications of pregnancy, delivery and three months of post-partum care);
- o Special protected groups (typically individuals who lose their cash assistance from AFDC or SSI due to earnings from work or increased Social Security benefits, but who may keep Medicaid for a period of time;
- o Recipients of adoption assistance and foster care under Title IV-E of the Social Security Act;

- o Certain Medicare beneficiaries (described later); and
- o All children born after September 30, 1983 in families with incomes at or below the FPL. (They must be given full Medicaid coverage until age 19. This phases in coverage, so that by the year 2002, all poor children under age 19 will be covered).

States also have the option to provide Medicaid coverage for other "categorically needy" groups. These optional groups share characteristics of the mandatory groups, but the eligibility criteria are somewhat more liberally defined. The broadest optional groups that States may cover (and for which they will receive Federal matching funds) under the Medicaid program include:

- o Infants up to age one and pregnant women not covered under the mandatory rules whose family income is no more than 185% of the FPL (the percentage of FPL is set by each State);
- o Children under age 21 who meet the AFDC income and resources requirements, but who otherwise are not eligible for AFDC;
- o Institutionalized individuals with income and resources below specified limits;
- o Persons receiving care under home and community-based waivers;
- o Certain aged, blind or disabled adults who have incomes above those requiring mandatory coverage, but below the ;
- o Recipients of State supplementary income payments;
- o "Medically needy" persons (described below); and
- o TB-infected persons who would be financially eligible for Medicaid at the SSI level (only for TB-related ambulatory services and TB drugs).

The option to have a "medically needy" (MN) program allows States to extend Medicaid eligibility to additional qualified persons with significant health care expenses who have income in excess of the mandatory or optional categorically needy levels. Such persons may "spend down" to Medicaid eligibility by incurring medical and/or remedial care expenses to offset their "excess" income, -- thereby reducing it to a level below the maximum income allowed by that State's Medicaid plan. States may also allow families to establish eligibility for MN coverage by paying monthly premiums to the State in an amount equal to the difference between the threshold allowance for income eligibility, and a family's income (reduced by any unpaid expenses incurred for medical care in previous months).

The "medically needy" Medicaid program does not have to be as extensive as the "categorically needy" program in a State, but there are certain requirements. If a State has any MN program, certain services must be provided as a minimum (the State may also choose

to include additional services); and in any MN program, a State is required to provide coverage to certain persons (certain children under age 18 and pregnant women who are MN). A State may choose to provide eligibility to other MN persons also: aged, blind, and/or disabled persons; to caretaker relatives of children deprived of parental support and care; and certain other financially eligible children up to age 21. In 1993, forty States had a MN program which provided at least some services for at least some groups.

The Medicare Catastrophic Coverage Act (MCCA) of 1988 made some significant changes which affected Medicaid. Although much of the MCCA was repealed, the Medicaid portions remain in effect. These changes protect enough of the institutionalized spouse' income and resources to assure a moderate level of support for the community spouse. As a result, less income and resources remain available to contribute to the cost of nursing home care, and the institutionalized spouse qualifies for Medicaid earlier than would have been true under previous legislation.

Medicaid does not provide medical assistance for all poor persons. Even under the broadest provisions of the Federal statute, the Medicaid program does not provide health care services, even for very poor persons, unless they are in one of the groups designated above. Low income is only one test for Medicaid eligibility; assets and resources also are tested against established thresholds (as determined by each State, within Federal guidelines).

Once eligibility for Medicaid is determined, coverage generally is retroactive to the third month prior to application. Coverage generally stops at the end of the month in which a person no longer meets the criteria of any Medicaid eligibility group. In addition to the Medicaid program, most States have additional "State-only" programs to provide medical assistance for specified poor persons who do not qualify for Medicaid. Federal matching funds are not provided for these State-only programs.

SCOPE OF MEDICAID SERVICES

Title XIX of the Social Security Act requires that, in order to receive Federal matching funds, a State must offer certain basic services to the categorically needy populations in any State program:

- o inpatient hospital services;
- o outpatient hospital services;
- o prenatal care;
- o physician services;
- o nursing facility (NF) services for persons aged 21 or older;
- o home health care for persons eligible for skilled-nursing services;
- o family planning services and supplies;
- o rural health clinic services;
- o laboratory and x-ray services;
- o pediatric and family nurse practitioners service;

- o certain Federally-qualified ambulatory & health-center services;
- o nurse-midwife services; and
- o early and periodic screening, diagnostic, and treatment (EPSDT) services for children under age 21.

States may also receive Federal assistance for funding if they elect to provide other optional services (currently 34 options). A few of the most commonly covered optional services under the Medicaid program include:

- o clinic services;
- o nursing facility services for the aged and disabled;
- o intermediate care facilities for the mentally retarded (ICFs/MR);
- o optometrist services and eyeglasses;
- o prescribed drugs;
- o prosthetic devices;
- o dental services; and
- o TB-related ambulatory services and drugs for qualifying persons.

States may provide home and community-based care to certain individuals with chronic impairments. Another option allows up to eight States (as a demonstration project) to establish and provide community-supported living arrangement services for individuals with mental retardation or a related condition.

AMOUNT AND DURATION OF MEDICAID SERVICES

Within broad Federal guidelines, States determine the amount and duration of services offered under their Medicaid programs. They may limit, for example, the days of hospital care or the number of physician visits covered. However, States are prohibited from limiting the duration of coverage for medically necessary inpatient hospital services provided to Medicaid-eligible children under age six who are in "disproportionate share hospitals" (defined on page 5) and to infants in all hospitals.

With certain exceptions, a State's Medicaid plan must allow recipients to have freedom of choice among participating providers of health care. States may provide and pay for Medicaid services through various pre-payment arrangements, such as a health maintenance organization (HMO). In general, States are required to provide comparable services to all categorically needy eligible persons. There are two important exceptions:

- 1) Health care services identified under the EPSDT program as being "medically necessary" for eligible children must be provided by Medicaid, even if those services are not included as part of the covered services in that State's plan; and
- 2) States may request home and community-based services "waivers" under which they offer an alternative health care package for persons who might otherwise be institutionalized under Medicaid.

States are not limited in the scope of services they can provide under such waivers as long as they are cost effective (except that, other than as a part of respite care, they may not provide room and board for such recipients).

PAYMENT FOR MEDICAID SERVICES

Medicaid operates as a vendor payment program, with States paying providers directly. Providers participating in Medicaid must accept the Medicaid reimbursement level as payment in full. With a few specific exceptions, each State has broad discretion in determining (within Federally-imposed upper limits and specific restrictions) the reimbursement methodology and resulting rate for services. States may impose nominal deductibles, coinsurance or co-payments on some Medicaid recipients for certain services. However, certain Medicaid recipients must be excluded from this cost sharing: pregnant women, children under age 18, hospital or nursing home patients who are expected to contribute most of their income to institutional care, and categorically needy enrollees in HMOs. Emergency services and family planning services must be exempt from co-payments for all recipients.

The portion of each State's Medicaid program which is paid by the Federal government, known as the Federal Medical Assistance Percentage (FMAP), is determined annually by a formula that compares the State's average per capita income level with the national income average. By law, the FMAP cannot be lower than 50 percent nor greater than 83 percent. The wealthier States have a smaller share of their costs reimbursed. In 1993, the FMAPs varied from 50 percent (paid to 11 States and D.C.) to 79.01 percent (to Mississippi), with the average Federal share among all States being 57.5 percent. The Federal government also shares in the State's expenditures for administration of the Medicaid program. Most administrative costs are matched at 50 percent for all States. However, depending on the complexities and need for incentives for a particular service, higher matching rates (75, 90 or 100 percent) are authorized for certain functions and activities.

Federal Medicaid payments to States have no set limit (cap); rather, the Federal government must match (at FMAP rates) State payments for the mandatory services plus the optional services that the individual State decides to provide for eligible recipients. Reimbursement rates must be sufficient to enlist enough providers so that Medicaid care and services are available under the plan at least to the extent that such care and services are available to the general population in that geographic area. Also, States must augment payment to qualified hospitals that provide inpatient services to a disproportionate number of Medicaid recipients and/or other low-income persons under what is known as the "disproportionate share hospital" (DSH) program. However, recent legislation has curtailed some States' large DSH payments (made by many States to get higher Federal matching monies with little or no increase in the States' share through refundable donations and provider taxes).

MEDICAID - MEDICARE RELATIONSHIP

The Medicare program (Title XVIII of the Social Security Act, entitled "Health Insurance for the Aged and Disabled") provides Hospital Insurance (HI, also known as Part A) and Supplementary Medical Insurance (SMI, also known as Part B). For persons aged 65 or older (and for certain disabled persons) who have insured status under Social Security or Railroad Retirement, coverage for HI is automatic. Coverage for SMI, however, requires payment of a monthly premium. Some aged and/or disabled persons are covered under both the Medicaid and Medicare programs. For Medicare beneficiaries who are also fully eligible for Medicaid, Medicare health care coverage is supplemented by services that are available under the State's Medicaid program. As each State elects, services such as eyeglasses, hearing aids, and nursing facility care beyond the 100 day limit covered by Medicare may be provided by the Medicaid program.

In addition, there are other Medicare beneficiaries (QDWIs, QMBs or SLMBs - see below) who are not fully eligible for Medicaid, but who do receive some help through the State Medicaid program's payment of part or all of the person's Medicare premiums and cost-sharing expenses. Persons identified as Qualified Disabled and Working Individuals ("QDWIs") who lost Medicare benefits because of their return to work, are allowed to purchase Medicare HI and SMI coverage. However, the HI premium (but not the SMI premium) must be paid by the State Medicaid program for those QDWIs with income below 200% of the Federal Poverty Level.

Medicaid assists certain other Medicare beneficiaries known as Qualified Medicare Beneficiaries ("QMBs") or Specified Low-Income Medicare Beneficiaries ("SLMBs") if they apply for help. For the QMBs, (those Medicare beneficiaries who have resources at or below twice the standard allowed under the SSI program, and with incomes below the), the State pays all the premiums and cost-sharing expenses for Medicare HI and SMI. For the SLMBs, (beneficiaries with resources like QMBs, but with slightly higher incomes: less than 110% of FPL in 1993 and 1994, and less than 120% in 1995), the Medicaid program pays (only) the SMI premiums.

If a person is a Medicare beneficiary, payments for any services covered by Medicare are made by the Medicare program before any payments are made by the Medicaid program. Medicaid is always the "payer of last resort".

MEDICAID TRENDS AND SUMMARY

Medicaid was initially formulated as a medical care extension of Federally funded income maintenance programs for the poor, with an emphasis on dependent children and their mothers. Over the years, however, Medicaid has been diverging from a firm tie to eligibility

for cash programs. Recent legislation assures Medicaid coverage to an expanded number of low-income pregnant women, poor children and to some Medicare beneficiaries who are not eligible for any cash assistance program. Such persons would not have been eligible for Medicaid under the earlier rules. Legislative changes also focused on continuation of specific benefits, fewer service limits, better quality of care, increased access, and enhanced outreach programs.

The Managed Care concept, which is growing rapidly within the Medicaid program, seeks to enhance access to quality care in a cost effective manner. As of June 30, 1993, 4.8 million Medicaid recipients had enrolled in Medicaid Managed Care programs, and the number is increasing rapidly.

The biggest change from the original Medicaid program has been the growth of Medicaid's substantial role in long-term care. Almost 45 percent of long-term care for persons using nursing facility or home health services in the USA in 1991 was paid for by the Medicaid program. A much larger percentage is paid by Medicaid for those persons who used more than four months of such care (i.e. "long-term"). Medicaid vendor payments for nursing facility and/or home health care services in 1993 totaled almost \$40 billion.

Medicaid policies for eligibility and services are complex, and vary considerably even among similar-sized and/or adjacent States. A person who is eligible for Medicaid in one State might not be eligible in another State. Services provided by one State may differ considerably in amount, duration, or scope from services provided in a similar or neighboring State. Eligibility and services can change within a State during the year.

Since its inception, increase in expenditures for the total Medicaid program has exceeded the consumer price index, and exceeded the increase in total numbers of persons served or services provided. This continued increasing growth in Medicaid expenditures seems primarily due to four factors:

- o the results of technological advances to keep more very low birth-weight babies and other critically ill or severely injured persons alive, but in need of continuing very expensive care;
- o the increase in rates of payments to providers of medical and health care services, when compared to general inflation;
- o the increase in the numbers of very old and disabled persons requiring extensive acute and/or long term health care and related services; and
- o the increase in the size of the Medicaid-covered populations (a result of the economic recession and Federal mandates).

Most Medicaid recipients require relatively small expenditures per person, per year. For example, preliminary data for 1993 indicate that Medicaid vendor payments for over 16 million children under

age 21 averaged only \$1,013 per child (yet that amounts to over \$16.5 billion dollars). Other groups, with far fewer persons, have much larger per-person expenditures. The 149,000 recipients of ICF/MR care in 1993 averaged vendor payments of \$59,156 per person (plus the cost of acute care and other services they received outside of the ICF/MR facility). And at least forty percent of persons with AIDS have their health care (estimated to average about \$40,000 per person/per year) paid for by Medicaid.

Although small in relative numbers, some individual patients (e.g., severely burned patients, accident victims with multiple severe head and brain injuries, organ transplant patients, medically fragile very premature babies, and others requiring very specialized, extensive and intensive medical care) can cost over \$4,000 per day/per person. And a few persons require many years of continuing extensive and very complex health care, costing several hundreds of thousands of dollars per person, year after year.

Preliminary data indicate that over 39.7 million persons were enrolled in Medicaid in 1993. Of these, 33.4 million (13.4 percent of the USA's population) received at least some health care service in 1993 through the Medicaid program. Total 1993 outlays for the Medicaid program include vendor payments of \$101.7 billion; payments for various premiums (for HMOs, Medicare, etc.) of almost \$7.8 billion; payments to disproportionate share hospitals of nearly \$16.6 billion; and administrative costs. This total increased from \$115.9 billion in 1992 to \$125.8 billion for 1993 (\$72.3 billion in Federal and \$53.5 billion in State monies). The 1993 Medicaid payments to health care vendors averaged \$3,042 per Medicaid recipient.

Medicaid's compound rate of growth for the existing program is now projected to be 12.7% per year between the years 1993 and 2000. Thus, if current expenditure trends continue, and there are no significant changes to the Medicaid program, then payments for the total (Federal and State) Medicaid program may well exceed \$290 billion by the year 2000.

The Medicaid programs must function within the Federal and State constraints of economic, social, and political factors. The U.S. Congress, the Department of Health and Human Services and the individual States continually seek to make improvements in the Medicaid programs' quality, effectiveness and extent of health care services. The need for expanded eligibility and for more extensive and enduring services are obvious. However, there is also great pressure to limit the Federal and State budgets. As a balance for these factors is sought, frequent revisions occur in Federal laws, in HCFA regulations, and in the States' Medicaid plans. Thus, the Medicaid program is continually changing.

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